BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KIMBERLY ANN GARZA 12888 Valley Crest Drive Oakdale, CA 95361 Registered Nurse License No. 560568 Respondent	Case No. 2007-23 OAH No. N2006080880

DECISION AFTER NON-ADOPTION

The attached Decision After Non-Adoption is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **February 7, 2008.**

IT IS SO ORDERED this **8th** day of **January**, **2007**.

LaTrascine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KIMBERLY ANN GARZA 12888 Valley Crest Drive Oakdale, CA 95361 Registered Nurse License No. 560568 Respondent	Case No. 2007-23 OAH No. N2006080880

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as it's Decision in the above entitled matter.

This Decision shall become effective on **January 25, 2008**.

IT IS SO ORDERED **December 27, 2007**.

La Francene W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
KIMBERLY ANN GARZA Oakdale, California 95361	Case No. 2007-23
Registered Nurse License No. 560568	OAH No. N2006080880
Respondent.	

DECISION AFTER NONADOPTION

Administrative Law Judge Ralph J. Venturino, Office of Administrative Hearings, State of California, heard this matter in Modesto, California on December 5, 6, 7, and 8, 2006, and February 15, 16, 21, and March 16 and 30, 2007, and in Sacramento, California on April 18, 2007. Leslie A. Burgermyer, Deputy Attorney General, Department of Justice, represented the Board of Registered Nursing, Department of Consumer Affairs. Respondent Kimberly Ann Garza appeared and was represented by Ellen Mendelson, Attorney at Law. The record was closed and the matter was submitted on April 18, 2007.

On July 2, 2007, Administrative Law Judge Venturino issued his Proposed Decision. On August 2, 2007, the Board issued its Notice of Nonadoption of the Proposed Decision. On September 19, 2007, the Board issued its Order Fixing Date for Submission of Written Argument. After review of the entire administrative record including the transcript and written argument from both parties' attorneys, the Board hereby renders its decision in this matter.

FACTUAL FINDINGS

1. Ruth Ann Terry, M.P.H., R.N., made the allegations contained in the Accusation in her official capacity as Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, State of California. The Board made the Accusation on July 24, 2006. Respondent Kimberly Ann Garza (Garza) timely filed a Notice of Defense to the Accusation.

2. At hearing, the Accusation was amended to conform to the proof offered at the hearing as follows:

(1) At page 5, line 2, "Oxybutynin" was stricken from paragraph 20(b);

(2) At page 5, lines 7 and 8, paragraph 15(a) was stricken;

(3) At page 9, line 8, "and meperidine" was stricken from paragraph 20(b);

(4) At page 9, line 13, "and October 23, 1999" was stricken from paragraph 20(b)(1);

(5) At page 9, line 15, "and Long's Drugs" was stricken from paragraph 20(b)(1);

(6) At page 9, line 21, "and Walgreen Pharmacy" was added to paragraph 20(b)(2);

(7) At page 10, lines 5 through 9, paragraph 20(b)(5) was stricken;

(8) At page 10, line 13, "and meperidine" was stricken from paragraph 20(c).

(9) At page 10, line 19, "and meperidine" was stricken from paragraph 20(d);

(10) At page 10, line 20, "and October 23, 1999" was stricken from paragraph 20(d);

(11) At page 10, line 22, "oxybutynin" was stricken from paragraph 20(d);

(12) At page 10, line 23, "and Long's Drugs" was stricken from paragraph 20(d);

3. The Board's official records, as of November 27, 2006, show that the Board issued Registered Nurse (RN) License number 560568 to Garza on October 21, 1999. The license was in full force and effect at the time of the allegations and was due to expire on March 31, 2007, unless renewed. There is no history of previous disciplinary action against Garza.

4. At the times relevant to the allegations, Garza worked as a registered nurse at Oak Valley Hospital District in Oakdale, California (Oak Valley or hospital) and did so until Oak Valley terminated her on March 28, 2001.[1] Garza worked at Oak Valley's medical/surgical unit, primarily on the night shift (6:00 p.m. until 6:30 a.m.). Garza was not a registered nurse when Oak Valley hired her on July 19, 1999. Garza obtained an interim permit to work under a supervisor and passed her nursing exams while working at Oak Valley. At the time of the hearing, Garza was working at Dameron Hospital (Dameron) and had been employed there for more than three years. Garza was not a practicing nurse after

[1] Garza did not challenge the termination.

her termination from Oak Valley until Dameron hired her (a period of approximately two years).

5. As part of the operating procedures at Oak Valley, Garza withdrew narcotic medications from a secure dispensing machine (PYXIS) using her password. The PYXIS machine recorded the withdrawals and tracked the medications withdrawn for each patient.[2] A transaction slip is furnished to assist a nurse with patient charting. Medication returns and waste witnessed by another nurse are also documented in the PYXIS system.

Patient #1: Medical Record #0010134101

6. On March 2, 2001, the doctor for Patient #1 issued a physician's order to the attending nurses for the patient to receive one to two tablets of Percodan, by mouth, every three hours, as needed for pain.

7. For Patient #1, Garza withdrew two Percodan tablets on March 3, 2001, at 2326 (11:26 p.m.), two Percodan tablets on March 4, at 0228 (2:28 a.m.), and two Percodan tablets on March 4, at 0356 (3:56 a.m.).

8. On March 3, 2001, Garza indicated in the hospital's medication record (commonly referred to as a Medication Administration Record or "MAR") that she administered Percodan to Patient #1 at 2330 (11:30 p.m.). In the MAR box where Garza indicated the time, she initialed the entry but, although there was room in the box, there was no indication of the number of tablets she gave to Patient #1.

9. The two Percodan tablets Garza withdrew on March 4, 2001, at 3:56 a.m. were within one and one-half hours of her previous withdrawal. They were withdrawn too soon based upon the instructions in Patient #1's March 2, 2001, physician's order that the patient receive one to two tablets of Percodan every three hours.

10. The medical charting for Patient #1, during Garza's March 3 to 4, 2001 shift, indicated one illegible time entry from Garza on March 4, in the MAR, with no number of tablets indicated, two Percodan indicated as administered in her 1900 assessment at the beginning of her shift, and two Percodan indicated as administered in her nursing notes at 0255. Garza's nursing notes (Time/Comments) entry immediately after 0255 is for 0500 and indicates that the patient is sleeping.

11. Garza's medical charting for Patient #1 failed to account for the two Percodan tablets Garza withdrew on March 4, 2001, at 3:56 a.m. that were withdrawn too soon based upon the instructions in Patient #1's physician's order. According to the Board's uncontroverted nursing expert, this creates an inference that Garza unlawfully obtained and possessed these controlled substances and therefore engaged in unprofessional conduct through fraud, deceit, misrepresentation, or subterfuge.

[2] Patients were charged for medications based upon the PYXIS records.

Patient #2: Medical Record #0010134859

12. On March 3, 2001, the doctor for Patient #2 issued a physician's order to the attending nurses for the patient to receive one to two tablets of Vicoden, by mouth, every four to six hours, as needed for pain.

13. For Patient #2, Garza withdrew from the PYXIS machine two Vicoden tablets on March 3, 2001, at 2115 (9:15 p.m.). Garza indicated on the MAR that she administered Vicoden to Patient #2 at what appears to be 2120 (9:20 p.m.), within five minutes of her withdrawal from the PYXIS machine. In the MAR box where Garza indicated the time, she initialed the entry. There also appears to be another mark under the time notation which Garza claims to be her symbolic entry for the number of pills. That mark is illegible but similar to her symbolic entry (resembling a dotted "T" [for one pill] or a dotted "pi" (Π) symbol [for two pills]). Another health care professional treating this patient and reading this record, would not be able to know, with any reasonable degree of certainty, the number of Vicoden pills Garza administered to Patient #2 on March 3, 2001, at 2120.

14. On March 3, 2001, the doctor for Patient #2 issued a physician's order to the attending nurses for the patient to receive four to eight milligrams (mg) of injectable morphine sulphate, every three hours, as needed for pain.

15. Garza withdrew a four mg dose of morphine sulphate for Patient #2 on March 4, 2001, at 0127 (1:27 a.m.), and documented the administration to Patient #2 on the MAR at 1:30 a.m. Garza also withdrew a four mg dose of morphine sulphate on March 4, at 2:37 a.m., and documented the administration to Patient #2 on the MAR at 3:00 a.m. Garza's administration of the morphine sulphate to Patient #2, at 3:00 a.m. on March 4, 2001, within one and one-half hours of the previous administration, was in contravention to Patient #2's March 3, 2001, physician's order that the patient receive four to eight milligrams (mg) of injectable morphine sulphate, every three hours.

16. Expert testimony proved that the standard of care requires that each administration of narcotic pain medication must comply with the time and dosage directions from the physician (i.e., even though Patient #2 was given a total of eight mg over one and half hours and could have been given all eight at 1:30 a.m. instead of only four).

17. At the same time Garza withdrew a four mg dose of morphine sulphate on March 4, 2001, at 1:27 a.m., for Patient #2, she also withdrew two Lortab/Vicoden tablets from the PYXIS machine. On the MAR, Garza documented the administration of the two Lortab/Vicoden tablets at 2:00 a.m., one half hour after withdrawal of the medication from the PYXIS machine and one half hour after administration of the injectable morphine sulphate. Garza did not indicate on Patient #2's 24 hour patient care record (patient care record) in her nursing notes, the administration of the two Vicoden, the reason for the administration of the two narcotic mediations or the reason for their administration so close in time. There are no patient chart notes detailing Patient #2's pain location and level of

pain. Garza also did not indicate in the patient's chart the effect of the medications on Patient #2. These failures constitute grossly incorrect patient charting errors.

18. On March 3, 2001, Garza indicated on Patient #2's patient care record that Patient #2 complained of pain at 2200 (10:00 p.m.) and that she administered Restoril "given for sleep." Restoril would not relieve Patient #2's pain issues.

Patient #3: Medical Record #0010137386/0018225

19. On March 12, 2001, the doctor for Patient #3 issued a physician's order to the attending nurses for the patient to receive a 5 mg Vicoden tablet, every four hours, as needed for severe pain. There was also a physician's order issued, on or before March 13, 2001, for one tablet of Darvocet, every six hours, as needed for severe pain.

20. Garza withdrew from the PYXIS machine one 5 mg Lortab/Vicoden tablet on March 14, 2001, at 1901 (7:01 p.m.) and another one on March 15, at 1:47 a.m., for Patient #3.

21. Garza withdrew from the PYXIS machine one Darvocet tablet on March 14, 2001, at 2115 (9:15 p.m.) and another one on March 15, at 4:13 a.m., for Patient #3.

22. Garza completed an assessment of Patient #3 at 1900 (7:00 p.m.), soon after beginning her shift. At that time, Garza indicated on the night shift column of the patient care record that the patient had a pain scale of È" out of È," that the pain location was the face and legs, and that the medications ordered were Darvocet and Vicoden. In the nursing notes column (Time/Comments) in the patient care record Garza indicated, that from 2000 until 0500, she alternated the pain medications she gave to Patient #3 (Vicoden and Darvocet). She also indicated that the medication was for shingle pain and leg ulcers, and Patient #3 tolerated the tablet medications. There was no indication of whether the patient complained of pain, when, exactly, the medications were given, and what were the specific results of the administration.

23. In her defense, Garza pointed to the lack of an MAR covering her shift on March 14 and 15, 2001, in the record. The MAR may well have indicated the time and amount of medications given, but would not have been sufficient to document the necessary assessments that are required to be entered into the nursing notes.

24. Garza's lack of specific documentation in the patient's records concerning the two tablets of Vicoden and the two tablets of Darvocet Garza withdrew on her March 14 to March 15, 2001 shift, especially the lack of a patient request and the specific numbers and times of administration, creates an inference that Garza unlawfully obtained and possessed these controlled substances and therefore engaged in unprofessional conduct through fraud, deceit, misrepresentation, or subterfuge. These failures of documentation constitute grossly incorrect patient charting errors.

Patient #4: Medical Record #0010138322/000186991

25. Garza withdrew a 10 mg dose of injectable morphine sulphate on March 15, 2001, at 0021 (12:21 a.m.), for Patient #4. The PYXIS record reflected a witness to the wasting of 2 mg. by Garza. According to Garza's notation in the MAR, she recorded the administration of the remaining 8 mg. of morphine sulphate at 0010 (11 minutes before withdrawal).[3]

26. The PYXIS records also indicated that Garza withdrew a four mg dose of morphine sulphate on March 15, 2001, at 4:00 a.m., for Patient #4. Garza marked the administration of 4 mg of morphine sulfate on the MAR for March 15, 2001, in illegible writing in between 0010 and 0605 time entries for 8 mg of morphine sulphate. This creates an inference that Garza unlawfully obtained and possessed these controlled substances and therefore engaged in unprofessional conduct through fraud, deceit, misrepresentation, or subterfuge. However, although difficult to read, upon very close inspection and after hearing testimony on the issue, the documented time appears to be 0420 (4:20 a.m.).[4] The charting is illegible without explanation but is apparently an attempt by Garza to chart the administration of, or otherwise account for, the four mg dose of morphine sulphate that she withdrew on March 15, 2001, at 4:00 a.m.

27. On March 16, 2001, the doctor for Patient #4 issued a physician's order to the attending nurses for the patient to receive one to two tablets of Percodan, every two hours, as needed for pain.

28. The PYXIS machine records indicated that Garza withdrew two Percodan tablets on March 16, 2001, at 0036 (12:36 a.m.) for Patient #4.[5]

29. Garza documented the administration of Percodan on March 16, 2001, at 0030 (12:30 a.m.) on two different MARs. On the MAR that looked like a computer printout, Garza indicated that she administered two Percodan. There was no indication on the other MAR for Patient #4 of the number of Percodan tablets Garza administered. This failure constitutes a grossly inconsistent patient charting error.

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[3] The 24 hour patent care charting for this patient was not in the record. There were other instances of time discrepancies in Garza's charting of the administration of morphine sulfate in the record. These were not pled in the Accusation and were not considered against Garza.

[4]The Board's assertion that the time indicated was "2420" was evidence that the entry was illegible. However, under the totality of the evidence, it was clear that Garza did not attempt to write "2420" but she put a line through "0420." There was no other indication of this kind of mistake in the record and Garza made many entries of times between 12:00 a.m. to 1:00 a.m. being written as "00XX" and not "24XX."

[5] There were no patient care records for Patient #4 entered as evidence.

Oak Valley Policies and Nursing Standard of Care

30. Janice Nickerson (Nickerson) testified for the Board concerning Oak Valley's hospital procedures for charting and medication administration. She has been a registered nurse since 1972, worked at Oak Valley as the Director of the Medical/Surgical unit during Garza's tenure, and was Garza's supervisor. Nickerson hired Garza and when she worked with Garza, she found Garza to be "delightful."

Among other things, Nickerson hired and evaluated staff, helped institute patient care policies and procedures, and reviewed patient documents. She was also trained to detect signs of drug diversions by nurses.

31. Nickerson reviewed Garza's patient records when she began receiving complaints about Garza from patients and one community member. Her investigations led to a counseling session with Garza, Garza's eventual suspension and termination from Oak Valley, and a complaint to the Board. Based upon Nickerson's complaint to the Board, the Board conducted the investigation that led to the filing of this matter.

32. Some of the charting irregularities Nickerson found were that Garza was not following doctors orders (she was not giving the appropriate drugs or she was giving too many). Her review of Garza's records showed that when Garza's chart entries appeared to indicate she had overmedicated a patient, the subsequent observation of the patient's symptoms did not match an overmedicated condition (such as being drowsy). Other than the four sets of, sometimes incomplete, patient records in evidence, there were no other documents evidencing the specific instances Nickerson relied upon to make the determinations she recalled during her testimony.

33. In addition to charting irregularities, Nickerson remembered, while testifying, that her investigation and inspection of Garza's charting records revealed that Garza removed 37% more narcotics from PYXIS than other nurses. The files from which Nickerson gleaned this information were not in evidence.

34. The Oak Valley nursing training policies included general hospital orientation (i.e. safety), nursing orientation, and on-the-job training from nursing managers. The nurse orientation training did not have an exact time frame but was ongoing after hire. Nickerson did not personally train Garza, but the hospital customarily followed a training procedure with preceptors and a checklist for new nurses.

35. Oak Valley relied on the training that nurses received in school and on its preceptor program to prepare nurses for work at the hospital.

36. Oak Valley nurses were trained and expected to chart pain management, including medication times and amounts, in the MAR and nursing notes (in 24 hour patient care records in the Time/Comments column). When Garza practiced at Oak Valley, one of its policies was that pain was considered the fifth vital sign that required a nurse's immediate

attention. The hospital required that pain intervention occur in less time than the usual 30-minute rule for routine medications. Garza's obligation as a nurse at Oak Valley would be to determine a patient's pain severity on a "1" to "10" scale, chart that assessment, and give the appropriate pain medication dose according to the physician's order.

37. At Oak Valley, patient charting was used to give a subsequent treating nurse or doctor full, detailed knowledge of the patient's last 24 hours, including all changes in the patient's conditions, all necessary interventions, and all of the patient's responses to those interventions.

38. The patient care record form used with the four patients in this case was developed by a group at Oakdale hospital and approved by Nickerson. The hospital policy was that a nurse was to use the shift assessment (middle) column when he or she began a shift. Subsequent to that time, and throughout the shift, the nurse was expected to use the Time/Comments (last) column for any changes during the shift. The hospital's standards throughout the shift were that there should be narrative (or block) charting every four hours, plus detailed charting on individual events, including pain management intervention. New nurses are trained on this and other forms when they start working at Oak Valley, during orientation by other nurses.

39. Nurses at Oak Valley were expected to indicate the administration of medication on the MAR and in the narrative nursing notes (Time/Comments) section. Indicating the administration of medication on the MAR only, or in the nursing notes only, was contrary Oak Valley policy and contrary to the way Garza would have been trained.

40. Use of block charting in the nursing notes (Time/Comments) column was part of Oak Valley's policies on March 14 and 15, 2001. But, when Garza used that technique in the patient's records in evidence, she did not use enough detail to comply with hospital policy. When Garza did not indicate how much pain medication was administered, and did not indicate any results of the interventions, her patient charting was contrary to hospital policy. The hospital's policy was that a nurse should always note the patient's complaint, any intervention, and the result of the intervention.

41. At all times relevant to this matter, Oak Valley also had a policy that patient charting entries must be legible to others.

42. During Ms. Nickerson's tenure at Oak Valley as a nursing director, she was aware of doctors complaining about nurses' record keeping or how they administered medication. She was unaware of any doctors complaining about Garza's documentation or medication administration.

43. At the time Garza was suspended for her charting errors, Ms. Nickerson did not believe that Garza was a risk to the public.

44. The standard of care for a registered nurse in the circumstances proved in this matter was enunciated by the Board's expert, Margaret Bajan (Psychiatric Registered Nurse Practitioner, Clinical Nurse, Addicted Nurse Case Manager, and holder of an Associates in Applied Science in Nursing). The Board established Bajan as an expert concerning nurse competence, nurse record keeping requirements, and the effect of unintelligible entries in a patient's chart.

The Board also established Bajan as an expert concerning behavior patterns for nurses addicted to narcotic pain medication. The pattern can include diverting hospital drugs, forging prescriptions, and record keeping incompetence.

45. The standard of care requires a registered nurse who cares for a patient to first make an assessment of the patient and enter a detailed note in the patient's record of the results of the assessment. The assessment, in order to be accurate and informed, must include a review of the patient's chart for all relevant information bearing on the patient's condition and circumstances.

46. A registered nurse is also required by the standard of care to be generally familiar with and comply fully with the hospital's published nursing procedures/protocols.

47. Bajan reviewed the documents the Board furnished to her including the investigation report and patient records. Her opinion was that Garza falsified patient medical records to aid and hide her diversion of narcotic pain medication. Bajan believed her opinion that Garza falsified patient medical records was supported by Garza's acts to falsify prescriptions since the combined acts would fit a behavior pattern common to nurses who were diverting drugs.

However, Bajan's opinion was undercut by her own inadvertent mistakes when she reviewed the medical records and prepared her expert report documenting Garza's alleged record keeping errors. In addition, her opinion was based upon the assumption that Garza also falsified prescriptions. Since the Board failed to establish that Garza falsified prescriptions, Bajan's opinion that Garza intentionally falsified patient medical records was also undercut because it lacked a foundation.

48. Bajan established, and Nickerson corroborated the factual findings above where Garza made unintelligible entries in patient medical records, and made entries that, individually, and in the aggregate, were grossly incorrect and grossly inconsistent. In the described incidents, the patients' charts did not clearly and accurately reflect whether the medication was given or wasted, the medication amounts, medication reasons, medication times, and/or effect of the medication in all the appropriate places. Clear, accurate, and complete patient charting is necessary for a doctor or another nurse to appropriately assess and treat the patient (in both the MAR and 24 hour patient care record, including the nursing progress notes).[6]

[6] This is true even though Garza successfully defended some of the Board's allegations and Bajan's opinions.

49. Bajan admitted that her opinions concerning Garza's charting abilities were based upon events that occurred in 2001, and that she could not offer an opinion of Garza's current ability as a nurse. She also confirmed that she was unaware of any of Garza's patients that suffered any actual harm.

50. Other doctors and nurses rely on correct and legible patient charting. Any change in status and the recordation of any medication given is especially important to document because a patient could be harmed by a potential under dose or overdose that could lead to a longer hospital stay or even death.

51. Bajan also had the opinion that if pain medication cannot be fully traced from withdrawal to administration or waste, the nurse who withdrew it illegally obtained and possessed all missing medication. This postulation has a basis but, due to the high burden of proof in these proceedings, this opinion serves to create an inference that is subject to additional proof and/or explanation.[7]

52. As found in Factual Findings 6 through 29, Garza violated Oak Valley's policies and practiced nursing beneath the standard of care in her care of patients 1, 2, 3, and

Alleged Forged Prescriptions

53. Two prescriptions written on Oak Valley prescription pads that appeared to bear Dr. Lawrence D. Podolsky's signature, dated December 4, 1999, were not signed by Dr. Podolsky.[8] One prescription was for Biaxin (an antibiotic) and one prescription was for Lortab. A woman attempted to fill the prescriptions on that same day at a Costco pharmacy.

54. Dr. Podolsky briefly talked on the telephone to the woman who attempted to fill the forged prescriptions at the Costco pharmacy on December 4, 1999. Dr. Podolsky said he had no reason to doubt that the woman in Costco was Garza, since she came to the telephone and responded to her name. But, Dr. Podolsky did not talk to the woman for any significant period of time and Dr. Podolsky did not identify Garza by her voice or in any other way.[9]

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[7] The Board's witness, Dr. Podolsky, testified that unclear patient charting of medication raises a question of where the medication went. When a person is being accused of fraud and theft, and the proof standard is "clear and convincing" a theory similar to res ipsa loquitur, where something is assumed to have happened because there is no other explanation, is not appropriate.

[8] Contrary to the Board's assertion, Garza had been a patient of Dr. Podolsky as a teenager. However, Garza was not his patient during the time of the alleged forged prescriptions.

[9] The Board also presented an uncorroborated hearsay description of the woman who attempted to pick up the prescriptions on December 4, 1999.

55. Dr. Podolsky also testified that other prescriptions written in Garza's name contained his forged signatures. These prescriptions were for Lortab and appear to be dated November 4 (Costco) and 29 (Walgreens), 1999.[10]

56. On September 4, 1999, Rite-Aid filled a Vicoden prescription for Kimberly Garza that was also allegedly authorized by Dr. Podolsky. Dr. Podolsky was not Garza's treating doctor at that time and Dr. Podolsky did not authorize the prescription.

57. Vicoden was similar to the medications that Garza's doctor, Dr. Edward Chock, prescribed for her post-surgical pain management issues in and around March and April of 1999.

58. Garza's supervisor at Oak Valley, Janice Nickerson, testified that she believed the writing on the forged prescriptions, in Dr. Podolsky's name, was Garza's because of similarities in certain letters and markings to Garza's writing on hospital documents. The letters and markings Nickerson compared were the small letter "q" used as shorthand for "every" in prescriptions, the "dotted t" marking used to indicate the number of tablets, the number _" in certain dates, and the cursive letter "z" in Garza's last name. Nickerson concluded that it was Garza's writing on the forged prescriptions that she reviewed for the hearing. She did not form this conclusion during her initial investigation of Garza's possible drug diversion prior to Garza being terminated from Oak Valley.

Nickerson was not testifying as a handwriting expert and the testimony was unclear concerning her lay opinion on the similarities in the cursive letter "z" in Garza's last name.[11]

59. The Board's allegation that Garza presented two forged and falsified prescriptions for Vicoden and Promethazine, on or about July 4, 2001, and another for Promethazine on or about July 17, 2001, was based upon a declaration from Dr. James Smith and his review of a Rite-Aid customer history report. Subsequent to his initial declaration, and upon review of copies of the alleged forged prescriptions, Dr. Smith confirmed, via declaration during the hearing, that he authorized the subject prescriptions and that his initial declaration was incorrect. The Board's expert, Ms. Bajan, wrongly assumed that these three

[10] Two other prescriptions were introduced, one dated May 14, 1999 (Costco), and one dated May 26, 1999 (Walgreens), but neither was specifically listed in the Accusation or within the timeframe for falsified prescriptions alleged in the Accusation.

[11] At least one of the alleged forged prescriptions in evidence (May 14, 1999) was signed for upon pickup. The signature on the prescription pickup form is similar to Garza's signatures on her Oak Valley employment forms and her medical record release forms, but they are not identical and vary in more than one way. There was no testimony specifically on this prescription pickup form and the prescription was not specifically listed in the Accusation or within the timeframe for falsified prescriptions alleged in the Accusation.

prescriptions were forged in her opinion concerning the behavioral patterns of nurse who is diverting drugs for her own use.[12]

60. The Board submitted testimony, via declaration, from two other doctors (Dr. Garfield Pickell and Dr. Mitchell Cohen), wherein they also reviewed Garza's customer history reports from three Modesto pharmacies, the Medicine Shoppe, Rite-Aid, and Longs Drugs. Both doctors testified that they saw prescriptions that were attributed to Garza that they believed they (or a colleague)[13] did not write. Their testimony was based upon a representation that a review of their records by the Stanislaus County Health Agency (where their older records are maintained), were no longer available or did not contain a record of the prescriptions, and that Garza was not a patient during the timeframe of the prescriptions (February and March 1999). The prescriptions were not specifically listed in the Accusation or within the timeframe for falsified prescriptions alleged in the Accusation. In fact, the Board struck the allegation relating to Longs Drugs from the Accusation. The alleged forged prescriptions were included on the Board's investigation report and the Board's expert, Ms. Bajan, relied on the report allegations to form her opinions.

61. The Board submitted testimony from a licensed pharmacist (since 1981) and pharmacy manager in Ms. Garza's hometown, Fernanda Franca Anderson. Ms. Anderson offered that pharmacy customer history records are an accurate reflection of what is dispensed to a client and are used to track billing and other prescription medicine information. She also offered that in her experience, in the small town where she works, and Garza lives, customers are asked for identification only if the pharmacist is unfamiliar with the customer or a new drug is being dispensed to an old customer. Ms. Anderson did not recognize Ms. Garza in the hearing room.

62. Garza testified, and Ms. Nickerson and Dr. Podolsky confirmed, that the doctors at Oak Valley sometimes left prescription pads at the nurses' station in violation of hospital policy.

63. Garza also testified that, in 2001, she filled prescriptions in the Medicine Shoppe and Rite Aid using her medical insurance and did not need to use a check, cash or credit card. Garza denied that she ever filled a prescription at Costco. In December 1999, when Costco called to ask about someone picking up a prescription for her, she said it was a mistake. She alerted Oak Valley hospital supervisors of the Costco incident during the time Janice Nickerson was out on leave. Ms. Nickerson confirmed she was on leave from Oak Valley when the Costco prescription was forged.

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[12] A Rite-Aide customer history report for Garza also listed a prescription for hydrocodone bitartrate/guaifensin from Dr. Carl Sufit. There was no testimony from Dr. Sufit concerning this prescription and the Board did not prove that Dr. Sufit did not prescribe this medication, as the Board alleged in the Accusation.

[13] Prior to June 1999, as a resident, Dr. Mitchell Cohen wrote prescriptions using Dr. Martin S. Cohen's license.

64. Immediately following the community member complaint about Garza's possible diversions, Garza voluntarily submitted to a drug test for the diverted drugs. The test result was negative.

Garza's Testimony

65. Garza contended that her charting problems may have been due to an unknown seizure disorder that finally hospitalized her on March 9, 2001. However, she admitted that she did not recall any seizures while she was on duty as a nurse. In addition, Garza was expected to self-report if not feeling well, including being confused or lethargic. No one else reported to Nickerson that Garza was lethargic or confused. As such, Garza's contention was not persuasive and, in any event, did not relieve her of her obligation to be competent if she chose to work.

66. As a defense to her one-time "block charting" on one patient's records, for one shift, Garza insisted that she would not need to document anything further if there was no change in the patient's status.

Garza's contention here is also unpersuasive. Garza admitted that she learned the nursing process five steps [(re)assessment, diagnosis, care plan, intervention, post-intervention evaluation] in school and was taught to record the necessary patient information relating to the nursing process. Garza agreed that the intervention step (which could include administration of pain medication) must be exactly recorded in a patient's chart (legible writings of the medication name, and the amount and time given). Garza also agreed that these nursing process five steps are important, are practiced continually, and were a part of her job at Oak Valley.

67. In addition, Garza also defended her missing entries by testifying that, sometimes, there was no room to write on certain documents in a patient's chart. Again, her contention is unpersuasive and does not absolve her from her job responsibilities. More important, Garza did not have an expert contradict the Board's expert concerning the general nursing practice standard of care, or Oak Valley's patient charting policies.

68. Oak Valley terminated Garza while she was on suspension. Prior to the patient and community member complaints and hospital investigation, Garza's work evaluations were generally good. Her 3-month evaluation showed that she was making progress, although some areas still needed improvement, and that Garza exhibited generosity and flexibility when taking shifts for other nurses. Her 6-month evaluation (January/February 2000) recognized that Garza had documentation problems and indicated that she needed to record more information in her nursing notes. Garza successfully completed probation in 2000.

69. The recent job evaluations Garza offered in evidence are not very detailed but show that Garza has received good reviews at her job with Dameron, including good reviews concerning her charting. The evaluations would have added more weight to her

rehabilitation if they were more detailed, there were more of them, and/or a colleague or supervisor corroborated her present job performance.

70. During her nursing career, Garza continued to take continuing education classes and has done so in the past year. One class she completed was a pain management seminar that is not a Board-required course. Garza has been working as a nurse without licensing discipline since 2003.

71. Garza's seizure disorder kept her from driving or working for two years (2001 until 2003). She also offered that her seizure disorder, and the related restrictions, were the reasons she did not follow-up with Oak Valley after her termination. Her most recent seizure happened at home, around September 2006.

72. Garza's testimony was riddled with failures to acknowledge mistakes she made or acknowledge fault in any of her actions and failures to act. This self-justification evidences a current failure of rehabilitation and the real possibility that she has not learned from her mistakes. However, Garza submitted commendations and good references (from 2003 through 2006) from her employer, patients, doctors, and a colleague, concerning her recent work.

Garza's Current Pain Management

73. Garza called one witness besides herself, her current pain management doctor, Dr. Edward Leonard Auen. Dr. Auen was Garza's pain management doctor at the time of the hearing and had been since she was referred to him by Dr. Edward Chock in June 2000. He prescribed various pain medications in rotation, in various doses, as is commonly done when treating a chronic pain condition. Rotation of various pain mediations is routine because a body may become tolerant and require more of the same medication for the same result. At one point, he determined Garza was on too much pain medication and adjusted her medications. At hearing, he admitted that Garza's prescription records for August and September 2000 showed more medication than Garza should have been taking and was surprised that Dr. Chock was prescribing similar pain medication, at that time, since Dr. Auen had become her pain management doctor. Dr. Auen offered that Garza indicated that the medications were not effective during certain times, and that it was not unusual for pain management patients to become pseudo-addicted and take more medications than directed because of body tolerance and other reasons.

74. Dr. Auen's records reflected that Garza had issues with a seizure or pseudo – seizure disorder in 2001 and 2002.

75. Dr. Auen's telephone logs from February and March 2001 reflected a refill request by Garza where she said she needed pain medication for the weekend of March 3 and 4, 2001 (the same dates of her alleged diversion from Oak Valley) that was not filled until March 24, 2001.

76. At the time of hearing, Dr. Auen was seeing Garza every three to four months. Garza is currently taking less medication because the pain cause was found and the current medication focuses on the specific cause of the pain. The pain medication helps Garza to function and there was no evidence that the medication interferes with her functioning. He was not concerned about her ability to function in June 2000, when he assessed her. Dr. Auen was concerned about Garza's ability to function only once, when he was giving her Demerol in mid-2000.

Investigation and Prosecution Timeline

77. To authenticate and allow the admittance of the Board's investigation report, the Board presented Mr. Rex Cowart, Northern Area Commander for the Division of Investigation for the Department of Consumer Affairs. At the times relevant to the Accusation, Mr. Cowart was a supervisor in charge of the Central Valley Field Office. The Central Valley Field Office (field office) covered investigations in Oakdale, California. Mr. Cowart would have reviewed the complaint and the request for service related to this matter, when it arrived in the field office.

78. Kim Wierenga, from Oak Valley human resources, and nursing supervisor Janis Nickerson prepared a complaint concerning Garza in July 2001, which the Board received in August 2001.

79. The Board requested a Department of Consumer Affairs investigation on December 14, 2001. The investigation began shortly after December 14, 2001.

80. Supervising Investigator Cowart assigned the investigation to Investigator Todd Smith. The assignment would have been made within 30 days of receiving the request for service on December 14, 2001. At that time, investigators in that office would have been handling 30 to 35 cases at once. Investigator Smith began with interviews in August 2002 (one year after the Board received the complaint).

81. As supervisor, Mr. Cowart would have reviewed Mr. Smith's investigative work during the investigation "at some point." Mr. Cowart had no specific recollection of reviewing Mr. Smith's investigative work. Mr. Smith's last work on the investigation was in April 2003. Subsequent to April 2003, Mr. Smith went on medical leave.

82. The investigation was not reassigned until March 2, 2004, when it was assigned to Investigator Jeff Trippon. The nearly one-year reassignment delay was due to a preference for continuity in investigators and the assumption that Investigator Smith would return from sick leave.

83. In the normal course of operations at the field office, as a supervisor, Mr. Cowart would have reviewed and approved the report if he found that the findings were supported. If the findings and conclusions were not supported, Mr. Cowart would have referred the matter back and there might be additional follow-up work done. There was no

referral back to the Field Investigator in this case but, some additional work was done after the report was concluded. Mr. Cowart signed the investigation report and agreed with its conclusions. At hearing, many of Mr. Cowart's responses concerning his oversight and involvement in the investigation took the form of "I would have done 'X'," based upon his recollection of his and his office's usual procedures. Investigator Cowart had no specific recollection of signing the report, no specific recollection of conversations, and no specific recollection of any of the quarterly meetings that "would have" happened.

Costs

84. A certification of the costs of investigation and enforcement of this matter incurred by the Board were made by the Executive Officer of the Board and were offered into evidence.[14] The declarations itemize investigative costs incurred by the Board from the Division of Investigation, Department of Consumer Affairs, and costs paid to the Attorney General for the prosecutorial services of the Deputy Attorney General and staff. The costs the Board sought are $36,244.25.

85. The costs are presumed reasonable.[15] Garza did not present any evidence to challenge the specified costs. Allocation of the reasonable costs will be analyzed in the legal conclusions below.

LEGAL CONCLUSIONS

Garza's Motion to Dismiss: Laches/Due Process Arguments

1. Garza's motion to strike the Accusation due to lack of competent evidence is denied. The decision below details the allegations that the Board proved by clear and convincing evidence at hearing

2. Garza's motion to strike the Accusation due to laches is denied.

Garza showed that there was an unreasonable delay in prosecution because there was a willful, nearly one-year delay during the four and a half year investigation of a matter that involved a nurse who, allegedly, was a danger to the public. However, Garza's laches argument is denied because she failed to prove that she was sufficiently prejudiced by the delay. Garza attempted to find witnesses when she received the Accusation in 2006 and discovered that persons with knowledge of the allegations had left the hospital or died, including a nurse who sometimes witnessed Garza's medication wasting and a doctor familiar with her seizure disorder. But, the Board had ample evidence concerning many of

[14] Business and Professions Code section 125.3.

[15] *Id.*

Garza's record keeping issues and Garza had sufficient opportunity to cross-examine the Board's witnesses, and did so effectively in certain instances.[16]

3. Garza's assertion of a violation of due process is denied to the extent that it relies on the theories asserted above. Any challenge to the constitutionality of the state laws governing this licensing prosecution is not within the jurisdiction of these proceedings.[17] Garza has the hearing record if she wishes to pursue a constitutional challenge to the process.[18]

Accusation Allegations

4. The burden of proof for all of the allegations made in this matter rests upon the Board and requires the Board to prove the allegations by "clear and convincing" evidence.[19] "Clear and convincing evidence requires a finding of high probability. Clear and convincing evidence means the proof in support of the allegations must be clear, explicit and unequivocal, i.e., so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind."[20]

5. Health and Safety Code section 4022 provides:

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

6. Biaxin is a dangerous drug within the meaning of Business and Professions Code section 4022 because it is available by prescription only.

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[16] (See *Gates v. Department of Motor Vehicles* (1979) 94 Cal.App.3d 921.)

[17] California Constitution, Article III, section 3.5.

[18] See *Delta Dental Plan v. Mendoza* (9 Cir. 1998) 139 F.3d 1289, 1296.

[19] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.

[20] *In Re Marriage of Weaver* (1990) 224 Cal.App.3d 478; *In Re David C.* (1984) 152 Cal.App.3d 1189, 1208.

7. Promethazine hydrochloride is a dangerous drug within the meaning of Business and Professions Code section 4022 because it is available by prescription only.

8. "Morphine/Morphine Sulphate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

9. "Percodan," (a brand of oxycodone hydrochloride), is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

10. "Hydrocodone" a.k.a. Hydrocodone Bitartrate, "Norco," "Lortab," and "Vicodin" are Schedule III controlled substances as designated by Health and Safety Code section 11056, subdivision (e)(4).

11. "Darvocet" (a brand name of propoxyphene napsylate) is a Schedule IV controlled substances as designated by Health and Safety Code section 11057, subdivision (c)(2).

12. "Restoril" (a brand name of Temazepam) is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(29).

13. The Board may take disciplinary action against a certified or licensed nurse, even if that license is expired,[21] for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

[¶...¶]

(d) Violating . . . directly or indirectly . . . any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it . . .[22]

14. "Incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.[23]

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[21] Business and Professions Code section 2764, in pertinent part.

[22] Business and Professions Code section 2761, in pertinent part.

[23] California Code of Regulations, title 16, section 1443.

15. A registered nurse shall be considered to be competent when he or she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.[24]

16. Incompetence "generally indicates 'an absence of qualification, ability or fitness to perform a prescribed [professional] duty or function.'"[25] "Incompetence is distinguishable from negligence, in that one 'may be competent or capable of performing a given duty but negligent in performing that duty.' Thus, 'a single act of negligence...may be attributable to remissiveness in discharging known duties, rather than...incompetency respecting the proper performance.'"[26] "While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a general lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute,

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[24] California Code of Regulations, title 16, section 1443.5; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052-53; *Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837 (*Pollack*).

[25] *Kearl*, pp. 1054-1055, citing *Pollack*, p.837.

[26] *Id., citing Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62.

we reject the notion that a single, honest failing in performing those duties-without more-constitutes the functional equivalent of incompetency justifying statutory sanctions."[27] Even when only one patient is involved, incompetence may be found where "...there were several acts or decisions by petitioner which were improper. This suggests more than 'a single, honest failing in performing [her] duties'."[28] Flawed reasoning leading to a decision to administer an incorrect treatment may be considered more "...incompetency respecting the proper performance of [her] duties than merely remissiveness in discharging known duties."[29]

17. As set forth above in Factual Finding 52, incorporating Factual Findings 6 through 29, Garza's nursing care of patients 1, 2, 3, and 4 violated Oak Valley's policies and fell beneath the standard of care in several material respects. These several acts and omissions were the product not of "a remissiveness in discharging known duties" or "a single, honest failing in performing those duties", but rather were the result of multiple errors, including missing and unintelligible entries. Her acts and omissions were therefore incompetent, within the meaning of that term in the foregoing authorities.

As a result, Garza's incompetent acts constituted unprofessional conduct, within the meaning of section 2761, subdivision (a), and California Code of Regulations, title 16, section 1443. Therefore, legal cause exists to revoke or suspend Garza's license.

18. Garza, as do all registered nurses, had a duty to perform her nursing duties for patients 1, 2, 3, and 4 within the standard of care, to wit, that degree of learning and skill ordinarily possessed by a reputable nurse practicing in the same or similar locality and under similar circumstances. It was her further duty to use the care and skill ordinarily used in like cases by reputable members of her profession practicing in the same or similar locality under similar circumstances and to use reasonable diligence and her best judgment in the exercise of her professional skill and in the application of her learning, in an effort to accomplish and complete her nursing duties.[30] A failure to fulfill any such duty is negligence.[31]

19. A nurse is not necessarily negligent because she errs in judgment, because her efforts prove unsuccessful or if the patient experiences a negative outcome.[32] A nurse is not negligent where the nurse, in exercising her professional judgment, chooses one of two or more recognized and approved methods of evaluation or treatment, where the choice turns

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[27] *Id*, citing *Pollack*, p. 839.

[28] *Id.*

[29] *Id.*

[30] *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Huffman v. Lundquist* (1951) 35 Cal.2d 465, 473; BAJI 6.00, 6.37 (7th Ed.)

[31] *Id.*

[32] *Fraijo v. Hartland Hospital* (1979) 99 Cal.App.3d 331, 340.

out to be wrong or is one not favored by other nurses.[33] She is negligent only if her error in judgment or lack of success is due to a failure to perform any of the duties required of reputable members of her profession practicing in the same or similar locality under similar circumstances.[34]

20. As used in section 2761, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."[35]

21. A lack of ordinary care defines negligent conduct. Gross negligence, on the other hand, is defined by an error or omission that is egregious and flagrant. "Gross negligence is 'the want of even scant care or an extreme departure from the ordinary standard of conduct.'"[36] "The use of the disjunctive in the definition indicates alternative elements of gross negligence; both need not be present before gross negligence will be found."[37] Thus, gross negligence may be found where the proof sustains a finding of either a want of even scant care or an extreme departure from the standard of care.

22. Business and Professions Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with *Section 11000*) *of the Health and Safety Code* or any dangerous drug or dangerous device as defined in Section 4022.

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[33] *Barton v. Owens* (1977) 71 Cal.App.3d 484, 489.

[34] *Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337; *Black v. Caruso* (1960) 187 Cal.App.2d 195.

[35] California Code of Regulations, title 16, section 1442.

[36] *Cooper v. Board of Medical Examiners* (1975) 49 Cal. App. 3d 931,941, quoting *Van Meter v. Bent Construction Company* (1956) 46 Cal 2d 588, 594.

[37] *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3d 1040.

(b) Use any controlled substance as defined in Division 10 (commencing with *Section 11000) of the Health and Safety Code*, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

[¶...¶]

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

23. As found in the Factual Findings, the Board proved that Garza's conduct toward patients 1, 2, 3, and 4 exhibited gross negligence in the form of grossly inconsistent and or grossly inaccurate patient charting in certain individual acts (Findings 17, 24, and 29) and in the aggregate (Findings 6 through 29), all of which constituted extreme departures from the standard of care.

24. Health and Safety Code section 4060 provides:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

25. Business and Professions Code section 4324, subdivision (a), states:

(a) Every person who signs the name of another, or of a fictitious person, or falsely makes, alters, forges, utters, publishes, passes, or attempts to pass, as genuine, any prescription for any drugs is guilty of forgery and upon conviction thereof shall be punished by imprisonment in the state prison, or by imprisonment in the county jail for not more than one year.

26. Health and Safety Code section 11170 provides that "no person shall prescribe, administer, or furnish a controlled substance for himself.

27. Health and Safety Code section 11173, subdivision (a), provides:

> (a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances (1) by fraud, deceit, misrepresentation or subterfuge, or (2) by the concealment of a material fact.

28. As indicated above, the Board proved, using the totality of the records, that, in 2001, Garza made illegible entries in patient charting and was incompetent in her record keeping. However, while the evidence presented at the hearing created a strong inference that Garza was diverting drugs for her own use, it did not establish to a reasonable certainty that Garza in fact diverted the drugs for her own use.

An alleged diversion taking place on dates near when Garza was seeking similar medications from her doctor created an inference that she was diverting the drugs for her own use. Additionally, the evidence showed Garza had a practice of sometimes documenting interventions, including the administration of medication, in only one area of a patient's chart. With one of two documents where Garza should have documented intervention, the Board proved Garza did not correctly document interventions because it proved that the interventions needed to be on both documents to meet the nursing standard of care. But, under the Board's burden of proof, it failed to prove that the medications were not documented anywhere, a sufficient number of times, thus leading to a clear and convincing conclusion that the drugs were diverted.

29. Health and Safety Code section 11368 states:

> Every person who forges or alters a prescription or who issues or utters an altered prescription, or who issues or utters a prescription bearing a forged or fictitious signature for any narcotic drug, or who obtains any narcotic drug by any forged, fictitious, or altered prescription, or who has in possession any narcotic drug secured by a forged, fictitious, or altered prescription, shall be punished by imprisonment in the county jail for not less than six months nor more than one year, or in the state prison.

30. Under the clear and convincing standard, the weight of the evidence in Factual Findings 53 through 64 does not support a finding that Garza forged or attempted to forge the prescriptions alleged in the Accusation in violation of the relevant statutes.

31. Garza presented some evidence of rehabilitation. Her most persuasive evidence is that she is now a more experienced nurse and these are the only allegations against her for substandard patient care. She presented evidence that she has good

professional skills and has practiced for more than three years, since the incidents in 2001, without any other claim of inappropriate care.

32. Unfortunately, Garza has not yet accepted any responsibility for her actions. She defended herself with self-justification, a significant portion of which was unpersuasive and not credible, sounding more like rationalization. Additionally, she has expressed no remorse for the potential for harm due to these types of patient charting errors and omissions. These two positions are consistent, but not particularly insightful. She cannot learn and benefit from a painful experience until she acknowledges the deficiencies that led to this action. Her professional performance since this incident has been good and complaint free. Her abilities have been recognized and appreciated by patients, peers and doctors who have recently worked with her.

33. The imposition of discipline is warranted, as the offenses were serious. But, outright revocation of the license is not warranted on these facts. On balance, it would not be contrary to the public interest in the quality and competence of its RNs to permit Garza to continue to practice as a RN. However, based on respondent's problems with her practice as determined above, the Board believes that in order to protect the public it is necessary that respondent be evaluated by a qualified health care professional to determine if her charting errors are in any way related to a substance abuse problem.

Cost Recovery

34. Costs of investigation and prosecution of the action are recoverable if the Board prevails in the action.[38] The Board has prevailed in the action. The $36,244.25 in of the costs of investigation and prosecution are reasonable as set forth in the Factual Findings 84 and 85. The recoverable portion of these costs as part of the disciplinary Order is to be analyzed using the standards set forth in *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 (*Zuckerman*).

35. In *Zuckerman*, a case in which the State Board of Chiropractic Examiners had disciplined a licensee, the Supreme Court of California dealt with the issue of cost recovery. The court held that "the Board must exercise its discretion to reduce or eliminate cost awards in a manner that will ensure that . . . [cost recovery] does not deter chiropractors with potentially meritorious claims or defenses from exercising their right to a hearing." The court established five rules that an agency must observe in assessing the amount to be charged. To some extent, these rules are similar to matters one would consider in determining whether costs are "reasonable," as is required by Code section 125.3. The court's rules, however, go beyond considerations of whether the costs are reasonable. The court said:

[38] Business and Professions Code section 125.3.

> [T]he Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a chiropractor who has committed some misconduct but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the chiropractor's "subjective good faith belief in the merits of his or her position" [Citation] and whether the chiropractor has raised a "colorable challenge" to the proposed discipline [Citation.] Furthermore, as in cost recoupment schemes in which the government seeks to recover from criminal defendants the cost of their state-provided legal representation [Citation] the Board must determine that the chiropractor will be financially able to make later payments. Finally, the Board may not assess the full costs of investigation and prosecution when it has conducted a disproportionately large investigation and prosecution to prove that a chiropractor engaged in relatively innocuous misconduct.

36. After considering and applying the *Zuckerman* factors, namely Garza's obvious "subjective good faith belief in the merits of her position," the costs awarded to the Board are reduced by 50 percent. Garza's disciplinary Order will include repayment of costs to the Board totaling $18,122.

ORDER

Registered Nurse License No. 535501, issued to Kimberly Ann Garza, by the Board of Registered Nursing, is REVOKED. However, the revocation is STAYED for a period of three (3) years, during which time Garza shall be on probation to the Board, subject to the following terms and conditions:

SEVERABILITY

Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

(1) OBEY ALL LAWS

Garza shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by the Garza to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, Garza shall submit completed fingerprint forms and fingerprint fees within

45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

(2) COMPLY WITH THE BOARD'S PROBATION PROGRAM

Garza shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Garza's compliance with the Board's Probation Program. Garza shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

(3) REPORT IN PERSON

Garza, during the period of probation, shall appear in person at interviews/ meetings as directed by the Board or its designated representatives.

(4) RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE

Periods of residency, or practice as a registered nurse outside of California, shall not apply toward a reduction of this probation time period. Garza's probation is tolled, if and when she resides outside of California. Garza must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Garza shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Garza shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Garza shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

(5) SUBMIT WRITTEN REPORTS

Garza, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to Garza's compliance with all the conditions of the Board's Probation Program. Garza shall immediately execute all release of information forms as may be required by the Board or its representatives.

Garza shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

(6) FUNCTION AS A REGISTERED NURSE

Garza, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

If Garza has not complied with this condition during the probationary term, and Garza has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the Garza's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

(7) EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS

Garza shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Garza shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Garza shall provide a copy of this decision to her employer and immediate supervisors, within ten (10) days of the effective date of this Decision, and prior to commencement of any other employment in nursing or other health care related position. Garza's employers shall certify to the Board that they received and read the Decision.

In addition to the above, Garza shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Garza shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

(8) SUPERVISION

Garza shall obtain prior approval from the Board regarding Garza's level of supervision

and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Garza shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Garza's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half of the hours Garza works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Garza at least twice during each shift worked.

(d) Home Health Care - If Garza is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with Garza as required by the Board each work day. Garza shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the Garza with or without Garza present.

(9) EMPLOYMENT LIMITATIONS

Garza shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool during the period of probation, unless the Board or its designee approves otherwise in writing.

Garza shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Garza shall not work in any other registered nursing occupation where home visits are required.

Garza shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Garza from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Garza shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Garza shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity unless the Board or its designee approves otherwise in writing.

If Garza is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

(10) COMPLETE A NURSING COURSE

Garza, at her own expense, shall enroll and successfully complete at least twenty (20) contact hours of nursing education, at the community college level or higher, in a subject matter relevant to the practice of registered nursing as directed and approved by the Board. The course should include education in the standards of care and appropriate protocols for patient charting. The course work requirements shall be determined as directed by the Board or its designee, and shall be completed no later than eighteen (18) months following the effective date of this Decision, unless the Board or its designee extends the time for good cause shown. Failure to complete the course work constitute cause for violation of this probation and/or immediate suspension of the license, in the discretion of the Board.

Garza shall obtain prior approval from the Board before enrolling in the course(s). Garza shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to Garza after photocopying them for its records.

(11) EVALUATION TO RULE OUT SUBTANCE ABUSE PROBLEMS

Within 45 days of the effective date of this decision, respondent, at her expense, shall have a licensed physician, nurse practitioner, or physician assistant, who is approved by the Board before the assessment is performed, submit an assessment to determine if Respondent has a substance abuse problem. Such an assessment shall be submitted in a format acceptable to the Board.

If the examiner conducting the physical health examination determines that the respondent is dependent upon drugs or alcohol, or has had problems with drugs or alcohol (i.e. drug dependence in remission or alcohol dependence in remission), that might reasonably affect the safe practice of nursing, then the respondent must further comply with the following additional terms and conditions of probation.

(A) PARTICIPATE IN TREATMENT/REHABILITATION PROGRAM FOR CHEMICAL DEPENDENCE - Respondent, at her expense, shall successfully complete during the probationary period or shall have successfully completed prior to commencement of probation a Board-approved treatment/rehabilitation program of at least six months duration. As required, reports shall be submitted by the program on forms provided by the Board. If respondent has not completed a Board-approved treatment/rehabilitation program prior to commencement of probation, respondent, within 45 days from the effective date of the decision, shall be enrolled in a program. If a program is not successfully completed within the first nine months of probation, the Board shall consider respondent in violation of probation.

Based on Board recommendation, each week respondent shall be required to attend at least one, but no more than five 12-step recovery meetings or equivalent (e.g., Narcotics Anonymous, Alcoholics Anonymous, etc.) and a nurse support group as approved and directed by the Board. If a nurse support group is not available, an additional 12-step meeting or equivalent shall be added. Respondent shall submit dated and signed documentation confirming such attendance to the Board during the entire period of probation. Respondent shall continue with the recovery plan recommended by the treatment/rehabilitation program or a licensed mental health examiner and/or other ongoing recovery groups.

(B) ABSTAIN FROM USE OF PSYCHOTROPIC (MOOD-ALTERING) DRUGS Respondent shall completely abstain from the possession, injection or consumption by any route of all psychotropic (mood altering) drugs, including alcohol, except when the same are ordered by a health care professional legally authorized to do so as part of documented medical treatment. Respondent shall have sent to the Board, in writing and within fourteen (14) days, by the prescribing health professional, a report identifying the medication, dosage, the date the medication was prescribed, the respondent's prognosis, the date the medication will no longer be required, and the effect on the recovery plan, if appropriate.

Respondent shall identify for the Board a single physician, nurse practitioner or physician assistant who shall be aware of respondent's history of substance abuse and will coordinate and monitor any prescriptions for respondent for dangerous drugs, controlled substances or mood-altering drugs. The coordinating physician, nurse practitioner, or physician assistant shall report to the Board on a quarterly basis respondent's compliance with this condition. If any substances considered addictive have been prescribed, the report shall identify a program for the time limited use of any such substances.

The Board may require the single coordinating physician, nurse practitioner, or physician assistant to be a specialist in addictive medicine, or to consult with a specialist in addictive medicine.

(C) SUBMIT TO TESTS AND SAMPLES - Respondent, at her expense, shall participate in a random, biological fluid testing or a drug screening program which the Board approves. The length of time and frequency will be subject to approval by the Board. The respondent is responsible for keeping the Board informed of respondent's current telephone number at all times. Respondent shall also ensure that messages may be left at the telephone number when she is not available and ensure that reports are submitted directly by the testing agency to the Board, as directed. Any confirmed positive finding shall be reported immediately to the Board by the program and the respondent shall be considered in violation of probation.

In addition, respondent, at any time during the period of probation, shall fully cooperate with the Board or any of its representatives, and shall, when requested, submit to such tests and samples as the Board or its representatives may require for the detection of alcohol, narcotics, hypnotics, dangerous drugs, or other controlled substances.

If respondent has a positive drug screen for any substance not legally authorized and not reported to the coordinating physician, nurse practitioner, or physician assistant, and the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

If respondent fails to participate in a random, biological fluid testing or drug screening program within the specified time frame, the respondent shall immediately cease practice and shall not resume practice until notified by the Board. After taking into account documented evidence of mitigation, if the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

(D) THERAPY OR COUNSELING PROGRAM - Respondent, at her expense, shall participate in an on-going counseling program until such time as the Board releases her from this requirement and only upon the recommendation of the counselor. Written progress reports from the counselor will be required at various intervals.

(12) COST RECOVERY

Garza shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $18,122 (Eighteen Thousand, One Hundred and Twenty-Two Dollars). Garza shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If Garza has not complied with this condition during the probationary term, and Garza has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the Garza's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

(13) VIOLATION OF PROBATION

If Garza violates the conditions of her probation, the Board after giving Garza notice and an opportunity to be heard, may set aside the stay order and impose the stayed revocation of Garza's license, or reimpose probation under the same or additional or other terms and conditions as the Board, in its discretion, determines appropriate under the circumstances.

If during the period of probation, an accusation or petition to revoke probation has been filed against Garza's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been finally decided by the Board.

(14) LICENSE SURRENDER

During Garza's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, Garza may surrender her license to the Board. The Board reserves the right to evaluate Garza's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, Garza will no longer be subject to the conditions of probation.

Surrender of Garza's license shall be considered a disciplinary action and shall become a part of Garza's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(A) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(B) One year for a license surrendered for a mental or physical illness.

(15) SUCCESSFUL COMPLETION OF PROBATION

Upon successful completion of probation, Garza's license shall be fully restored.

This Decision shall become effective on January 25, 2008.

IT IS SO ORDERED this 27th day of December.

LaFrancine Tate

LAFRANCINE TATE
BOARD OF REGISTERED NURSING
STATE OF CALIFORNIA

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KIMBERLY ANN GARZA,** **a.k.a. KIMBERLY ANN ANDERSON** 15808 Victory Road Oakdale, CA 95361 Registered Nurse License No. 560568 Respondent.	Case No. 2007-23 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about October 21, 1999, the Board issued Registered Nurse License Number 560568 to Kimberly Ann Garza, also known as Kimberly Ann Anderson ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2007, unless renewed.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a

temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

5. Code section 2761 states, in pertinent part:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> "(a) Unprofessional conduct, which includes, but is not limited to, the following: [¶] (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .
>
> "(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it . . . ."

6. Code section 2762 states, in pertinent part:

> "In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> "(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

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"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Code section 4022 states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a --------," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

8. Code section 4060 states:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

"This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

"Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices."

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9. Code section 4324, subdivision (a), states:

> "Every person who signs the name of another, or of a fictitious person, or falsely makes, alters, forges, utters, publishes, passes, or attempts to pass, as genuine, any prescription for any drugs is guilty of forgery and upon conviction thereof shall be punished by imprisonment in the state prison, or by imprisonment in the county jail for not more than one year."

10. Health and Safety Code ("H&S") section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself. Controlled substances are defined, among other things, in H&S Code sections 11055 through 11057, inclusive.

11. H&S Code section 11173, subdivision (a), states, in pertinent part:

> "(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact."

12. H&S Code section 11368 states:

> "Every person who forges or alters a prescription or who issues or utters an altered prescription, or who issues or utters a prescription bearing a forged or fictitious signature for any narcotic drug, or who obtains any narcotic drug by any forged, fictitious, or altered prescription, or who has in possession any narcotic drug secured by forged, fictitious, or altered prescription shall be punished by imprisonment in the county jail for not less than six months nor more than one year, or in the state prison."

13. California Code of Regulations, title 16, section ("Regulation") 1443 states:

> "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY

14. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS AT ISSUE

15. The following drugs are dangerous drugs within the meaning of Code section 4022 in that they are available by prescription only: "Biaxin;" "Oxybutynin;" and "Promethazine hydrocloride."

16. H&S Code section 11055 designates, in relevant part, the following Schedule II controlled substances:

a. "Meperidine hydrochloride," a derivative of pethidine, is a Schedule II controlled substance as designated by H&S section 11055, subdivision (c)(17).

b. "Morphine/Morphine Sulfate" is a Schedule II controlled substance as designated by H&S Code section 11055, subdivision (b)(1)(M).

c. "Percodan," a brand of oxycodone hydrochloride, is a Schedule II controlled substance as designated by H&S Code section 11055, subdivision (b)(1)(N).

17. H&S Code section 11056 designates, in relevant part, the following Schedule III controlled substances:

a. "Hydrocodone bitartrate/guaifensin" is a Schedule III controlled substance as designated by H&S Code section 11056, subdivision (e)(4).

b. "Norco" and "Lortab" are combination drugs containing hydrocodone bitartrate and acetaminophen and are Schedule III controlled substances as designated by H&S Code section 11056, subdivision (e)(4).

c. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 500 mg acetaminophen per tablet and is a Schedule III controlled substance as designated by H&S Code section 11056, subdivision (e)(4).

18. H&S Code section 11057 designates, in relevant part, the following Schedule IV controlled substances:

a. "Darvocet," a brand of propoxyphene napsylate, is a Schedule IV controlled substance as designated by H&S Safety Code section 11057, subdivision (c)(2).

b. "Restoril," a brand of temazepam, is a Schedule IV controlled substance, as designated by H&S Code section 11057, subdivision (d)(29).

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about March 2001, while employed as a registered nurse at Oak Valley District Hospital ("OVDH") located in Oakdale, California, Respondent was guilty of incompetence within the meaning of Regulation 1443 when she persistently disregarded OVDH's policies and procedures for administration of narcotic medication and failed to account for narcotic medication that she withdrew for patients, as follows:

Patient 0010134101:

a. On or about March 2, 2001, the physician for Patient 0010134101 issued an order for Percodan, one (1) or two (2) tablets by mouth every three (3) hours if necessary for pain. On March 3, 2001, at 2330 hours, Respondent documented in the patient's MAR that she administered Percodan to the patient, but failed to write the number of tablets given.

b. On March 3, 2001, and March 4, 2001, Respondent withdrew a total of six (6) Percodan tablets from the Pyxis within a period of approximately four and one-half (4-½) hours when, in fact, the physician's order called for the administration of one (1) to two (2) tablets of the medication *every three (3) hours.*

Patient 0010134859:

c. On or about March 3, 2001, the physician for Patient 0010134859 issued an order for Vicodin, one (1) or two (2) tablets by mouth every four (4) to six (6) hours if needed for pain. On that same day, at 2120 hours, Respondent documented in the patient's MAR that she administered Vicodin to the patient, but failed to write the number of tablets given.

d. On or about March 3, 2001, the physician for Patient 0010134859 issued an order for a morphine sulfate 4 to 8 mg injectable every three (3) hours if needed for pain. On March 4, 2001, at 0127 hours, Respondent withdrew one (1) morphine sulfate 4 mg injectable from the Pyxis and documented in the patient's MAR that she administered the medication to

the patient at 0130 hours. At 0237 hours, Respondent withdrew another morphine sulfate 4 mg injectable from the Pyxis and documented in the patient's MAR that she administered the medication to the patient at 0300 hours. In fact, the physician's order called for the administration of the morphine sulfate *every three (3) hours.*

e. On March 4, 2001, at 0127 hours, Respondent withdrew one (1) morphine sulfate 4 mg injectable and two (2) Lortab/Vicodin tablets from the Pyxis for Patient 0010134859. That same day, Respondent documented in the patient's MAR that she administered the morphine sulfate to the patient at 0130 hours and the Lortab/Vicodin to the patient at 0200 hours. Respondent failed to safely administer the medication to the patient by failing to document on the patient care record her rationale for withdrawing both narcotics at the same time and for administering them to the patient one-half (½) hour apart. Further, Respondent failed to document the effects of the medication on the patient, where the patient's pain was located, or the intensity of the pain.

f. On March 3, 2001, at 2200 hours, Respondent documented on the patient care record for Patient 0010134859 that she administered Restoril to the patient "for sleep." In fact, the patient was complaining of pain and Restoril would not address the patient's pain issues.

Patient 0010137386:

g On or about March 14, 2001, and March 15, 2001, Respondent withdrew a total of two (2) tablets of Lortab/Vicodin 5 mg and two (2) tablets of Darvocet N100 from OVDH's Pyxis Medstation ("Pyxis") as ordered by the physician for Patient 0010137386 for treatment of the patient's severe pain. Respondent failed to administer the medication to the patient or failed to document administration of the medication in the patient's Medication Administration Record ("MAR") or the 24 Hour Patient Care Record ("patient care record") and otherwise failed to account for the two (2) tablets of Lortab/Vicodin 5 mg and two (2) tablets of Darvocet N100.

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Patient 0010138322:

h. On or about March 16, 2001, the physician for Patient 0010138322 issued an order for Percodan, one (1) to two (2) tablets by mouth every four (4) hours as needed for pain. On that same day, at 0030 hours, Respondent documented in the patient's MAR that she administered Percodan to the patient, but failed to write the number of tablets given.

SECOND CAUSE FOR DISCIPLINE

(Unlawfully Obtaining, Possessing, and Prescribing Controlled Substances and Dangerous Drugs)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that in and between September 1999 and July 2001, Respondent did the following:

Unlawfully Obtaining Controlled Substances:

a. In or about March 2001, while employed and on duty as a registered nurse at OVDH, Respondent obtained the controlled substances Lortab, Darvocet, Percodan, and morphine sulfate by fraud, deceit, misrepresentation, or subterfuge, in violation of H&S Code section 11173, subdivision (a), as follows:

(1) On or about March 14, 2001, and March 15, 2001, Respondent withdrew a total of two (2) tablets of Lortab/Vicodin 5 mg and two (2) tablets of Darvocet N100 from the Pyxis under the name of Patient No. 0010137386, but failed to administer the medication to the patient or failed to document administration of the medication in the patient's MAR and patient care record and otherwise failed to account for the disposition of the two (2) tablets of Lortab/Vicodin and two (2) tablets of Darvocet.

(2) On March 4, 2001, at 0356 hours, Respondent withdrew two (2) Percodan tablets from the Pyxis under the name of Patient No. 0010134101, when in fact, Respondent had already administered the maximum dose of the medication to the patient as called for in the physician's order. Further, Respondent failed to administer the two (2) Percodan tablets to the patient or failed to document administration of the medication in the

patient's MAR and patient care record and otherwise failed to account for the disposition of the two (2) tablets of Percodan.

(3) On March 15, 2001, at 0400 hours, Respondent withdrew a morphine sulfate 4 mg/ml injectable from the Pyxis under the name of Patient No. 0010138322, but failed to chart the administration of the medication in the patient's MAR or otherwise account for the disposition of the 4 mg/ml injectable of morphine sulfate.

b. In and between September 1999, and July 2001, Respondent obtained the controlled substances Lortab, Vicodin, hydrocodone bitartrate/guaifensin, and meperidine for her own personal use by fraud, deceit, misrepresentation, or subterfuge. Respondent signed the name of another on prescriptions or falsely made, altered, forged, uttered, published, or passed as genuine prescriptions for the narcotics and had the prescriptions filled at various pharmacies located in Modesto and Oakdale, California, as follows:

(1) On or about September 4, 1999, and October 23, 1999, Respondent presented forged or falsified prescriptions for varying quantities of Vicodin to Rite-Aid Pharmacy and Long's Drugs located in Oakdale, California, that had allegedly been issued or authorized by Dr. Podolsky. In fact, Dr. Podolsky had not issued or authorized any prescriptions for Respondent. Further, Respondent had never been a patient of Dr. Podolsky.

(2) On or about November 4, 1999, and November 29, 1999, Respondent wrote or issued prescriptions for varying quantities of Lortab on prescription forms belonging to OVDH, forged the signature of Dr. Lawrence Podolsky on the prescription forms as the authorizing physician, and presented the forged/falsified prescriptions to Costco Pharmacy located in Modesto, California. In fact, Dr. Podolsky had not prescribed the medication to Respondent as she was not one of his patients.

(3) On or about December 31, 1999, Respondent presented a forged or falsified prescription for hydrocodone bitartrate/guaifensin to Rite-Aid Pharmacy located in Oakdale, California, that had allegedly been issued or authorized by Dr. Carl Sufit. In fact, Dr. Sufit had not issued or authorized the prescription.

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(4) On or about July 4, 2001, Respondent presented a forged or falsified prescription for thirty (30) tablets of Vicodin to Rite-Aid Pharmacy located in Oakdale, California, that had allegedly been issued or authorized by Dr. James Smith. In fact, Dr. Smith had not issued or authorized the prescription.

(5) On or about October 6, 2000, Respondent presented a forged or falsified prescription for one-hundred twenty (120) tablets of meperidine 50 mg to Rite-Aid Pharmacy located in Oakdale, California, that had allegedly been issued or authorized by Dr. Gervacio Diaz. In fact, Dr. Diaz had not issued or authorized the prescription. Further, Respondent had never been a patient of Dr. Diaz.

Unlawful Possession of Controlled Substances:

c In and between September 1999, and July 2001, Respondent possessed varying quantities of the controlled substances Lortab, Vicodin, hydrocodone bitartrate/ guaifensin, and meperidine without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, as set forth in paragraph 20, subparagraph (b) above, in violation of Code section 4060.

Prescription of Controlled Substances and Dangerous Drugs:

d. In and between September 1999, and July 2001, Respondent prescribed varying quantities of the controlled substances Lortab, Vicodin, hydrocodone bitartrate/ guaifensin and meperidine for herself, as set forth in paragraph 20, subparagraph (b), above, in violation of Health and Safety Code section 11170. Further, on or about October 23, 1999, December 4, 1999, July 4, 2001, and July 17, 2001, Respondent prescribed the dangerous drugs oxybutynin, Biaxin, and promethazine for herself and had the prescriptions filled at Costco Pharmacy located in Modesto, California, and Rite-Aid Pharmacy and Longs Drugs located in Oakdale, California.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

21. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section

2762, subdivision (e), in that in or about March 2001, while employed and on duty as a registered nurse at OVDH, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Lortab, Darvocet, Percodan, morphine sulfate, and Restoril, as follows:

Patient 0010134101:

a. On March 4, 2001, at 0356 hours, Respondent withdrew two (2) Percodan tablets from the hospital's Pyxis under the name of Patient 0010134101, but failed to chart the administration of the Percodan in the patient's MAR or the patient care record and otherwise account for the disposition of the two (2) Percodan tablets.

Patient 0010134859:

b. On March 3, 2001, at 2115 hours, Respondent withdrew two (2) tablets of Lortab/Vicodin from the Pyxis under the name of Patient 0010134859, charted the administration of the Vicodin in the patient's MAR at 2120 hours, but failed to chart the administration of the Vicodin in the patient care record or otherwise account for the administration of the two (2) tablets of Vicodin.

c On March 4, 2001, at 0127 hours, Respondent withdrew two (2) tablets of Lortab/Vicodin from the Pyxis under the name of Patient 0010134859, charted the administration of the Vicodin in the patient's MAR at 0200 hours, but failed to chart the administration of the Vicodin in the patient care record or otherwise account for the administration of the two (2) tablets of Vicodin.

Patient 0010137386:

d. On March 14, 2001, at 1901 hours, Respondent withdrew one (1) tablet of Lortab/Vicodin 5 mg from the hospital's Pyxis under the name of Patient 0010137386, but failed to chart the administration of the Lortab/Vicodin in the patient's MAR or patient care record and otherwise failed to account for the disposition of the one (1) Lortab/Vicodin tablet.

e On March 14, 2001, at 2115 hours, Respondent withdrew one (1) tablet of Darvocet-N100 from the hospital's Pyxis under the name of Patient 0010137386, but failed to

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chart the administration of the Darvocet in the patient's MAR or patient care record and otherwise failed to account for the disposition of the one (1) Darvocet tablet.

f. On March 15, 2001, at 0147 hours, Respondent withdrew one (1) tablet of Lortab/Vicodin 5 mg from the hospital's Pyxis under the name of Patient 0010137386, but failed to chart the administration of the Lortab/Vicodin in the patient's MAR or patient care record and otherwise failed to account for the disposition of the one (1) Lortab/Vicodin tablet.

g On March 15, 2001, at 0413 hours, Respondent withdrew one (1) tablet of Darvocet N100 from the hospital's Pyxis under the name of Patient 0010137386, but failed to chart the administration of the Darvocet in the patient's MAR or patient care record and otherwise failed to account for the disposition of the one (1) Darvocet tablet.

Patient 0010138322:

h On March 15, 2001, at 0021 hours, Respondent withdrew a morphine sulfate 10 mg/ml injectable from the Pyxis under the name of Patient 0010138322, made entries in the Pyxis that 8 mg of the medication were administered to the patient and the remaining two (2) mg were wasted, as witnessed by another staff member, but inconsistently charted the administration of 8 mg morphine sulfate in the patient's MAR at 0010 hours and the administration of 4 mg morphine sulfate in that same record at 2420 hours.

i On March 15, 2001, at 0400 hours, Respondent withdrew a morphine sulfate 4 mg/ml injectable from the Pyxis under name of Patient 0010138322, but failed to chart the administration of the medication in the patient's MAR or otherwise account for the disposition of the 4 mg/ml injectable of morphine sulfate.

j On March 16, 2001, at 0036 hours, Respondent withdrew two (2) Percodan tablets from the Pyxis under Patient 0010138322's name, but inconsistently charted in the patient's MAR that the Percodan was administered to the patient at 0030 hours.

FOURTH CAUSE FOR DISCIPLINE

(Attempt to Obtain Controlled Substances)

22. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (d), she attempted to obtain the controlled substance Lortab by fraud, deceit,

misrepresentation, or subterfuge, in violation of Code section 2761, subdivision (a), and Health and Safety Code section 11173, subdivision (a). On or about December 4, 1999, Respondent wrote or issued a prescription for fifty (50) tablets of Lortab 10 mg on a prescription form belonging to OVDH, forged Dr. Lawrence Podolsky's signature on the prescription form as the authorizing physician, and presented the forged/falsified prescription to Costco Pharmacy located in Modesto, California, in order to obtain the narcotic. In fact, Dr. Podolsky had not issued or prescribed the Lortab to Respondent as she was not one of his patients.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 560568, issued to Kimberly Ann Garza, also known as Kimberly Ann Anderson;

2. Ordering Kimberly Ann Garza, also known as Kimberly Ann Anderson, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/24/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant